

(b) On the basis of this evaluation, the department or agency head may approve or disapprove the application or proposal, or enter into negotiations to develop an approvable one.

§ 219.121 [Reserved]

§ 219.122 Use of Federal funds.

Federal funds administered by a department or agency may not be expended for research involving human subjects unless the requirements of this policy have been satisfied.

§ 219.123 Early termination of research support: Evaluation of applications and proposals.

(a) The department or agency head may require that department or agency support for any project be terminated or suspended in the manner prescribed in applicable program requirements, when the department or agency head finds an institution has materially failed to comply with the terms of this policy.

(b) In making decisions about supporting or approving applications or proposals covered by this policy the department or agency head may take into account, in addition to all other eligibility requirements and program criteria, factors such as whether the applicant has been subject to a termination or suspension under paragraph (a) of this section and whether the applicant or the person or persons who would direct or has have directed the scientific and technical aspects of an activity has have, in the judgment of the department or agency head, materially failed to discharge responsibility for the protection of the rights and welfare of human subjects (whether or not the research was subject to federal regulation).

§ 219.124 Conditions.

With respect to any research project or any class of research projects the department or agency head may impose additional conditions prior to or at the time of approval when in the judgment of the department or agency head additional conditions are necessary for the protection of human subjects.

PART 220—COLLECTION FROM THIRD PARTY PAYERS OF REASONABLE COSTS OF HEALTHCARE SERVICES

Sec.

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- 220.12 Definitions.

AUTHORITY: 5 U.S.C. 301; 10 U.S.C. 1095.

SOURCE: 55 FR 21748, May 29, 1990, unless otherwise noted.

§ 220.1 Purpose and applicability.

This part implements the provisions of 10 U.S.C. 1095. In general, 10 U.S.C. 1095 establishes the statutory obligation of third party payers to reimburse the United States the reasonable costs of healthcare services provided by facilities of the Uniformed Services to most Uniformed Services medical care beneficiaries who are also covered by a third party payer's plan. This part establishes the Department of Defense interpretations and requirements applicable to all healthcare services subject to 10 U.S.C. 1095.

[57 FR 41100, Sept. 9, 1992]

§ 220.2 Statutory obligation of third party payer to pay.

(a) *Basic rule.* Pursuant to 10 U.S.C. 1095(a)(1), a third party payer has an obligation to pay the United States the reasonable costs of healthcare services provided in any facility of the Uniformed Services to a Uniformed Services beneficiary who is also a beneficiary under the third party payer's plan. The obligation to pay is to the extent that the beneficiary would be eligible to receive reimbursement or indemnification from the third party payer if the beneficiary were to incur

the costs on the beneficiary's own behalf.

(b) *Application of cost shares.* If the third party payer's plan includes a requirement for a deductible or copayment by the beneficiary of the plan, then the amount the United States may collect from the third party payer is the reasonable cost of the care provided less the appropriate deductible or copayment amount.

(c) *Claim from United States exclusive.* The only way for a third party payer to satisfy its obligation under 10 U.S.C. 1095 is to pay the facility of the uniformed service or other authorized representative of the United States. Payment by a third party payer to the beneficiary does not satisfy 10 U.S.C. 1095.

(d) *Assignment of benefits not necessary.* The obligation of the third party payer to pay is not dependent upon the beneficiary executing an assignment of benefits to the United States.

[55 FR 21748, May 29, 1990, as amended at 57 FR 41101, Sept. 9, 1992]

§ 220.3 Exclusions impermissible.

(a) *Statutory requirement.* Under 10 U.S.C. 1095(b), no provision of any third party payer's plan having the effect of excluding from coverage or limiting payment for certain care if that care is provided in a facility of the uniformed services shall operate to prevent collection by the United States.

(b) *General rules.* Based on the statutory requirement, the following are general rules for the administration of 10 U.S.C. 1095 and this part.

(1) Express exclusions or limitations in third party payer plans that are inconsistent with 10 U.S.C. 1095(b) are inoperative.

(2) No objection, precondition or limitation may be asserted that defeats the statutory purpose of collecting from third party payers.

(3) Third party payers may not treat claims arising from services provided in facilities of the uniformed services less favorably than they treat claims arising from services provided in other hospitals.

(4) No objection, precondition or limitation may be asserted that is contrary to the basic nature of facilities of the uniformed services.

(c) *Specific examples of impermissible exclusion.* The following are several specific examples of impermissible exclusions, limitations or preconditions. These examples are not all inclusive.

(1) *Care provided by a government entity.* A provision in a third party payer's plan that purports to disallow or limit payment for services provided by a government entity or paid for by a government program (or similar exclusion) is not a permissible ground for refusing or reducing third party payment.

(2) *No obligation to pay.* A provision in a third party payer's plan that purports to disallow or limit payment for services for which the patient has no obligation to pay (or similar exclusion) is not a permissible ground for refusing or reducing third party payment.

(3) *Exclusion of military beneficiaries.* No provision of an employer sponsored program or plan that purports to make ineligible for coverage individuals who are uniformed services health care beneficiaries shall be permissible.

(4) *No participation agreement.* The lack of a participation agreement or the absence of privity of contract between a third party payer and a facility of the uniformed services is not a permissible ground for refusing or reducing third party payment.

[55 FR 21748, May 29, 1990, as amended at 57 FR 41101, Sept. 9, 1992]

§ 220.4 Reasonable terms and conditions of health plan permissible.

(a) *Statutory requirement.* The statutory obligation of the third party to pay is not unqualified. Under 10 U.S.C. 1095(a)(1) (as noted in § 220.2 of this part), the obligation to pay is to the extent the third party payer would be obliged to pay if the beneficiary incurred the costs personally.

(b) *General rules.* (1) Based on the statutory requirement, after any impermissible exclusions have been made inoperative (see § 220.3 of this part), reasonable terms and conditions of the third party payer's plan that apply generally and uniformly to services provided in facilities other than facilities of the uniformed services may also be applied to services provided in facilities of the uniformed services.

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(2) Third party payers are not required to treat claims arising from services provided in facilities of the uniformed services more favorably than they treat claims arising from services provided in other hospitals.

(c) *Specific examples of permissible terms and conditions.* The following are several specific examples of permissible terms and conditions of third party payer plans. These examples are not all inclusive.

(1) *Generally applicable coverage provisions.* Generally applicable provisions regarding particular types of medical care or medical conditions covered by the third party payer's plan are permissible grounds to refuse or limit third party payment.

(2) *Generally applicable utilization review provisions.* Generally applicable provisions of the third party payer's plan requiring preadmission screening, second surgical opinions, retrospective review or other similar utilization review activities are permissible grounds to refuse or reduce third party payment if such refusal or reduction is required by the third party payer's plan. Such provisions, however, may not be applied in a manner that would result in claims arising from services provided by facilities of the uniformed services being treated less favorably than claims arising from services provided by other hospitals.

(3) *Restrictions in HMO plans.* Generally applicable exclusions in Health Maintenance Organization (HMO) plans of nonemergency services provided outside the HMO (or similar exclusions) are permissible.

§ 220.5 Records available.

Pursuant to 10 U.S.C. 1095(c), facilities of the uniformed services, when requested, shall make available to representatives of any third party payer from which the United States seeks payment under 10 U.S.C. 1095 for inspection and review appropriate health care records (or copies of such records) of individuals for whose care payment is sought. Appropriate records which will be made available are records which document that the services which are the subject of the claims for payment under 10 U.S.C. 1095 were provided as claimed and were provided in a

manner consistent with permissible terms and conditions of the third party payer's plan. This is the sole purpose for which patient care records will be made available. Records not needed for this purpose will not be made available.

§ 220.6 Certain payers excluded.

(a) *Medicare and Medicaid.* Under 10 U.S.C. 1095(d), claims for payment from the Medicare or Medicaid programs (titles XVIII and XIX of the Social Security Act) are not authorized.

(b) *Supplemental plans.* CHAMPUS (see 32 CFR part 199) supplemental plans and income supplemental plans are excluded from any obligation to pay under 10 U.S.C. 1095.

(c) *Third party payer plans prior to April 7, 1986.* 10 U.S.C. 1095 is not applicable to third party payer plans which have been in continuous effect without amendment or renewal since prior to April 7, 1986. Plans entered into, amended or renewed on or after April 7, 1986, are subject to 10 U.S.C. 1095.

(d) *Third party payer plans prior to November 5, 1990, in connection with outpatient care.* The provisions of 10 U.S.C. 1095 and this section concerning outpatient services are not applicable to third party payer plans:

(1) That have been in continuous effect without amendment or renewal since prior to November 5, 1990; and

(2) For which the facility of the Uniformed Services or other authorized representative for the United States makes a determination, based on documentation provided by the third party payer, that the policy or plan clearly excludes payment for such services. Plans entered into, amended or renewed on or after November 5, 1990, are subject to this section, as are prior plans that do not clearly exclude payment for services covered by this section.

[55 FR 21748, May 29, 1990, as amended at 57 FR 41101, Sept. 9, 1992]

§ 220.7 Remedies.

(a) Pursuant to 10 U.S.C. 1095(e)(1), the United States may institute and prosecute legal proceedings against a third party payer to enforce a right of the United States under 10 U.S.C. 1095 and this part.

(b) Pursuant to 10 U.S.C. 1095(e)(2), an authorized representative of the United States may compromise, settle or waive a claim of the United States under 10 U.S.C. 1095 and this part.

(c) The authorities provided by 32 CFR part 90 regarding collection of indebtedness due the United States shall also be available to effect collections pursuant to 10 U.S.C. 1095 and this part.

§ 220.8 Reasonable costs.

(a) *Diagnosis related group (DRG)-based method for calculating reasonable costs for inpatient services*—(1) *In general.* As authorized by 10 U.S.C. 1095(f)(3), the calculation of reasonable costs for purposes of collections for inpatient hospital care under 10 U.S.C. 1095 and this part shall be based on diagnosis related groups (DRGs). Costs shall be based on the inpatient full reimbursement rate per hospital discharge, weighted to reflect the intensity of the principal diagnosis involved. The average cost per case shall be published annually as an inpatient standardized amount. A relative weight for each DRG shall be the same as the DRG weights published annually for hospital reimbursement rates under the Civilian Health and Medicare Program of the Uniformed Services (CHAMPUS) pursuant to 32 CFR 199.14(a)(1).

(2) *Standardized amount.* The standardized amount shall be determined by dividing the total costs of all inpatient care in all military medical treatment facilities by the total number of discharges. This will produce a single national standardized amount. The Department of Defense is authorized, but not required by this part to calculate three standardized amounts, one each for large urban areas, other urban areas, and rural areas, utilizing the same distinctions in identifying those areas as is used for CHAMPUS under 32 CFR 199.14(a)(1).

(3) *DRG relative weights.* Costs for each DRG will be determined by multiplying the standardized amount per discharge by the DRG relative weight. For this purpose, the DRG relative weights used for CHAMPUS pursuant to 32 CFR 199.14(a)(1) shall be used.

(4) *Adjustments for outliers, area wages, and indirect medical education.* The De-

partment of Defense may, but is not required by this part, to adjust cost determinations in particular cases for length-of-stay outliers (long stay and short stay), cost outliers, area wage rates, and indirect medical education. If any such adjustments are used, the method shall be comparable to that used for CHAMPUS hospital reimbursements pursuant to 32 CFR 199.14(a)(1)(iii)(E), and the calculation of the standardized amount under paragraph (a)(2) of this section will reflect that such adjustments will be used.

(5) *Identification of professional and hospital costs.* For purposes of billing third party payers other than automobile liability and no-fault insurance carriers, inpatient billings will be subdivided into two categories:

(i) Hospital charges (which refers to routine service charges associated with the hospital stay and ancillary charges).

(ii) Professional charges (which refers to professional services provided by physicians and certain other providers).

(6) Outpatient billings will continue to be subdivided into three categories:

(i) Hospital charges (which refers to routine service charges associated with the outpatient visit).

(ii) Professional charges (which refers to professional services provided by physicians and certain other providers).

(iii) Ancillary charges (which refers to diagnostic and treatment services, other than professional services, provided by components of the hospital in connection with the outpatient visit).

(b) *Unified per diem rates for care provided prior to October 1, 1992.* For inpatient hospital care provided prior to October 1, 1992, the computation of reasonable costs shall be based on the unified per diem full reimbursement rate for all clinical categories of hospital care. For purposes of this paragraph (and paragraph (c) of this section), charges for patients hospitalized before and after the October 1 start date shall be based on the determination method in effect for the respective periods of hospitalization.

(c) *Clinical groups per diem rates for care provided on or after October 1, 1992,*

and prior to October 1, 1994. For inpatient hospital care provided on or after October 1, 1992, and prior to October 1, 1994, the computation of reasonable costs shall be based on the per diem full reimbursement rate applicable to the clinical category of services involved. Patients treated in an intensive care unit any time during the 24 hour nursing period shall be charged the intensive care per diem charge in lieu of a charge to the clinical service to which the patient is currently assigned. For this purpose, 12 clinical groups are established, as follows:

(1) Medical Care Services. This includes internal medicine, cardiology, dermatology, endocrinology, gastroenterology, hematology, nephrology, neurology, oncology, pulmonary and upper respiratory disease, rheumatology, physical medicine, clinical immunology, HIV III—Acquired Immune Deficiency Syndrome (AIDS), infectious disease, allergy, and medical care not elsewhere classified.

(2) Surgical Care Services. This includes general surgery, cardiovascular and thoracic surgery, neurosurgery, ophthalmology, oral surgery, otolaryngology, pediatric surgery, plastic surgery, proctology, urology, peripheral vascular, trauma service, head and neck service and surgical care not elsewhere classified.

(3) Obstetrical and Gynecological Care.

(4) Pediatric Care. This includes pediatrics, nursery, adolescent pediatrics and pediatric care not elsewhere classified.

(5) Orthopaedic Care. This includes orthopaedics, podiatry and hand surgery.

(6) Psychiatric Care and Substance Abuse Rehabilitation.

(7) Family Practice Care.

(8) Burn Unit Care.

(9) Medical Intensive Care/Coronary Care.

(10) Surgical Intensive Care.

(11) Neonatal Intensive Care.

(12) Organ and Bone Marrow Transplants.

(d) *Medical services and subsistence charges included.* Medical services charges pursuant to 10 U.S.C. 1078 or subsistence charges pursuant to 10 U.S.C. 1075 are included in the claim

filed with the third party payer pursuant to 10 U.S.C. 1095. For any patient of a facility of the Uniformed Services who indicates that he or she is a beneficiary of a third party payer plan, the usual medical services or subsistence charge will not be collected from the patient to the extent that payment received from the payer exceeds the medical services or subsistence charge. Thus, except in cases covered by § 220.8(k), payment of the claim made pursuant to 10 U.S.C. 1095 which exceeds the medical services or subsistence charge, will satisfy all of the third party payer's obligation arising from the inpatient hospital care provided by the facility of the Uniformed Services on that occasion.

(e) *Per visit rates.* (1) As authorized by 10 U.S.C. 1095(f)(2), the computation of reasonable costs for purposes of collections for most outpatient services shall be based on a per visit rate for a clinical specialty or subspecialty. The per visit charge shall be equal to the outpatient full reimbursement rate for that clinical specialty or subspecialty and includes all routine ancillary services. A separate charge will be calculated for cases that are considered same day/ambulatory surgeries. These rates shall be updated and published annually. As with inpatient billing categories, clinical groups representing selected board certified specialties/subspecialties widely accepted by graduate medical accrediting organizations such as the Accreditation Council for Graduate Medical Education (ACGME) or the American Board of Medical Specialties will be used for ambulatory billing categories. Related clinical groups may be combined for purposes of billing categories.

(2) The following clinical reimbursement categories are representative, but not all-inclusive of the billing category clinical groups referred to in paragraph (e)(1) of this section: Internal Medicine, Allergy, Cardiology, Diabetic, Endocrinology, Gastroenterology, Hematology, Hypertension, Nephrology, Neurology, Nutrition, Oncology, Pulmonary Disease, Rheumatology, Dermatology, Infectious Disease, Physical

Medicine, General Surgery, Cardiovascular and Thoracic Surgery, Neurosurgery, Ophthalmology, Organ Transplant, Otolaryngology, Plastic Surgery, Proctology, Urology, Pediatric Surgery, Family Planning, Obstetrics, Gynecology, Pediatrics, Adolescent Pediatrics, Well Baby, Orthopaedics, Cast, Orthotic Laboratory, Hand Surgery, Podiatry, Psychiatry, Psychology, Child Guidance, Mental Health, Social Work, Substance Abuse Rehabilitation, Family Practice, and Occupational and Physical Therapy.

(f) *Same day/ambulatory surgery rate.* A separate charge will be calculated for cases that are same day/ambulatory surgeries.

(g) *Special rule for services ordered and paid for by a facility of the Uniformed Services but provided by another provider.* In cases where a facility of the Uniformed Services purchases ancillary services or procedures, from a source other than a Uniformed Services facility, the cost of the purchased services will be added to the standard rate. Examples of ancillary services and other procedures covered by this special rule include (but are not limited to): laboratory, radiology, pharmacy, pulmonary function, cardiac catheterization, hemodialysis, hyperbaric medicine, electrocardiography, electroencephalography, electroneuromyography, pulmonary function, inhalation and respiratory therapy and physical therapy services.

(h) *Special rule for certain ancillary services ordered by outside providers and provided by a facility of the Uniformed Services.* If a Uniformed Services facility provides certain ancillary services, prescription drugs or other procedures requested by a source other than a Uniformed Services facility and are not incident to any outpatient visit or inpatient services, the reasonable cost will not be based on the usual Diagnostic Related Group (DRG) or per visit rate. Rather, a separate standard rate shall be established based on the accumulated cost of the particular service, drugs, or procedures provided during a twenty-four hour period ending at midnight. Effective March 15, 1996, this special rule applies only to services, drugs or procedures having a cost of at least \$25. The reasonable cost for the

services, drugs or procedures to which this special rule applies shall be calculated and made available to the public annually.

(i) *Miscellaneous health care services.* Some outpatient services are provided which may not traditionally be provided in hospitals or which are not traditional clinical specialties or subspecialties. This includes, but is not limited to, land ambulance service, air ambulance service, hyperbaric treatments, dental care services and immunizations.

(1) The charge for ambulance services shall be based on the full costs of operating the ambulance service.

(2) For hyperbaric treatments (such as high pressure oxygenation treatments, burn treatments and decompression treatments in response to diving incidents), charges will be based on the full operating costs of the hyperbaric treatment services.

(3) Charges for dental services (including oral diagnosis and prevention, periodontics, prosthodontics (fixed and removable), implantology, oral surgery, orthodontics, pediatric dentistry and endodontics) will be based on a full cost of the dental services.

(4) The charge for immunizations, allergin extracts, allergic condition tests, and the administration of certain medications when these services are provided in a separate immunizations or shot clinic, will be based on the average full cost of these services, exclusive of any costs considered for purposes of any outpatient visit. A separate charge shall be made for each immunization, injection or medication administered.

(j) *Special rule for former Public Health Service facilities.* In connection with the former Public Health Service facilities described in § 220.12(c), the computation of reasonable costs for purposes of collections under 10 U.S.C. 1095 and this part may differ from such computations under § 220.8. Reasonable costs for such facilities shall be determined by the Department of Defense based on approximate government costs for similar services under CHAMPUS.

(k) *Special rules for TRICARE Resource Sharing Agreements and Partnership Program providers—(1) In general.* Paragraph (k) establishes special Third

Party Collection program rules for TRICARE Resource Sharing Agreements and Partnership Program providers.

(i) TRICARE Resource Sharing Agreements are agreements under the authority of 10 U.S.C. 1096 and 1097 between uniformed services treatment facilities and TRICARE managed care support contractors under which the TRICARE managed care support contractor provides personnel and other resources to the uniformed services treatment facility concerned in order to help the facility increase the availability of health care services for beneficiaries. TRICARE is the managed care program authorized by 10 U.S.C. 1097 (and several other statutory provisions) and established by regulation at 32 CFR 199.17.

(ii) Partnership Program providers provide services in facilities of the uniformed services under the authority of 10 U.S.C. 1096 and the CHAMPUS program. They are similar to providers providing services under TRICARE Resource Sharing Agreements, except that payment arrangements are different. Those functioning under TRICARE Resource Sharing Agreements are under special payment arrangements with the TRICARE managed care contractor; those under the Partnership Program file claims under the standard CHAMPUS program on a fee-for-service basis.

(2) *Special rule for TRICARE Resource Sharing Agreements.* Services provided in facilities of the uniformed services in whole or in part through personnel or other resources supplied under a TRICARE Resource Sharing Agreement are considered for purposes of this part as services provided by the facility of the uniformed services. Thus, third party payers will receive a claim for such services in the same manner and for the same costs as any similar services provided by a facility of the uniformed services. This paragraph (k)(2) becomes effective April 1, 1997.

(3) *Special rule for Partnership Program providers.* For inpatient services for which the professional provider services were provided by a Partnership Program participant, the professional charges component of the bill will be deleted from the claim from the facil-

ity of the uniformed services. In these cases, the uniformed service facility's claim shall not be considered solely a "facility charge." As an all-inclusive bill, room and board, nursing services and all ancillary services (radiology, pharmaceuticals, respiratory therapy, etc.) are factored into the bill. The third party payer will receive a separate claim for professional services directly from the individual health care provider. The same is true for the professional services provided on an outpatient basis under the Partnership Program. Claims from Partnership Program providers are not covered by 10 U.S.C. 1095 or this part, but are governed by statutory and regulatory requirements of the CHAMPUS program.

(l) *Alternative determination of reasonable costs.* Any third party payer that can satisfactorily demonstrate a prevailing rate of payment in the same geographic area for the same or similar aggregate groups of services that is less than the standard rate (or other amount as determined under paragraphs (f) through (k) of this section) of the facility of the Uniformed Services may, with the agreement of the facility of the Uniformed Services (or other authorized representatives of the United States), limit payments under 10 U.S.C. 1095 to that prevailing rate for that aggregate category of services. The determination of the third party payer's prevailing rate shall be based on a review of valid contractual arrangements with other facilities or providers constituting a majority of the services for which payment is made under the third party payer's plan. This paragraph does not apply to cases covered by § 220.11.

[57 FR 41101, Sept. 9, 1992, as amended at 59 FR 49002, Sept. 26, 1994; 61 FR 6542, Feb. 21, 1996; 62 FR 941, Jan. 7, 1997]

§ 220.9 Rights and obligations of beneficiaries.

(a) *No additional cost share.* Pursuant to 10 U.S.C. 1095(a)(2), uniformed services beneficiaries will not be required to pay to the facility of the uniformed services any amount greater than the normal medical services or subsistence charges (under 10 U.S.C. 1075 or 1078). In every case in which payment from a third party payer is received, it will be

considered as satisfying the normal medical services or subsistence charges, and no further payment from the beneficiary will be required.

(b) *Availability of healthcare services unaffected.* The availability of healthcare services in any facility of the Uniformed Services will not be affected by the participation or non-participation of a Uniformed Services beneficiary in a health care plan of a third party payer. Whether or not a Uniformed Services beneficiary is covered by a third party payer's plan will not be considered in determining the availability of healthcare services in a facility of the Uniformed Services.

(c) *Obligation to disclose information.* Uniformed services beneficiaries are required to provide correct information to the facility of the uniformed services regarding whether the beneficiary is covered by a third party payer's plan. Intentionally providing false information or otherwise willfully failing to satisfy this obligation are grounds for disqualification for health care services from facilities of the uniformed services.

[55 FR 21748, May 29, 1990, as amended at 57 FR 41102, Sept. 9, 1992]

§ 220.10 Special rules for Medicare supplemental plans.

(a) *Statutory obligation of Medicare supplemental plans to pay.* The obligation of a Medicare supplemental plan to pay shall be determined as if the facility of the Uniformed Services were a medicare-eligible provider and the services provided as if they were Medicare-covered services. A Medicare supplemental plan is required to pay only to the extent that the plan would have incurred a payment obligation if the services had been furnished by a Medicare eligible provider.

(b) *Inpatient hospital care charges.* (1) Notwithstanding the provisions of § 220.8, charges to Medicare supplemental plans for inpatient hospital care services provided to beneficiaries of such plans shall not, for any admission, exceed the Medicare inpatient hospital deductible amount.

(2) Only one deductible charge shall be made per hospital admission (or Medicare benefit period), regardless of whether the admission is to a facility

of the Uniformed Services or a Medicare certified civilian hospital. To ensure that a Medicare supplemental insurer is not charged the inpatient hospital deductible twice when an individual who is entitled to benefits under both DoD retiree benefits and Medicare, the following payment rules apply:

(i) If a dual beneficiary is first admitted to a Medicare-certified hospital and is later admitted to a facility of the Uniformed Services within the same benefit period initiated by the admission to the Medicare-certified hospital, the facility of the Uniformed Services shall not charge the Medicare supplemental insurance plan an inpatient hospital deductible.

(ii) If a dual beneficiary is admitted first to a facility of the Uniformed Services and secondly to a Medicare-certified hospital within 60 days of discharge from the facility of the Uniformed Services, the facility of the Uniformed Services shall refund to the Medicare supplemental insurer any inpatient hospital deductible that the insurer paid to the facility of the Uniformed Services so that it may pay the deductible to the Medicare-certified hospital.

(c) *Charges for health care services other than the inpatient hospital deductible amount.* (1) The Assistant Secretary of Defense (Health Affairs) may establish special charge amounts for Medicare supplemental plans to collect reasonable costs for inpatient and outpatient copayments and other services covered by the Medicare supplemental plan. Any such schedule of charge amounts shall:

(i) Be based on percentage amounts of the per diem, per visit and other rates established by § 220.8 comparable to the percentage amounts of beneficiary financial responsibility under Medicare for the service involved;

(ii) Include adjustments, as appropriate, to identify major components of the all inclusive per diem or per visit rates for which Medicare has special rules.

(iii) Provide for offsets and/or refunds to ensure that Medicare supplemental insurers are not required to pay a limited benefit more than one time in cases in which beneficiaries receive

similar services from both a facility of the uniformed services and a Medicare certified provider; and

(iv) Otherwise conform with the requirements of this section and this part.

(2) If collections are sought under paragraph (c) of this section, the effective date of such collections will be prospective from the date the Assistant Secretary of Defense (Health Affairs) provides notice of such collections, and will exempt policies in continuous effect without amendment or renewal since the date the Assistant Secretary of Defense (Health Affairs) provides notice of such collections.

(d) *Medicare claim not required.* Notwithstanding any requirement of the Medicare supplemental plan policy, a Medicare supplemental plan may not refuse payment to a claim made pursuant to this section on the grounds that no claim had previously been submitted by the provider or beneficiary for payment under the Medicare program.

(e) *Exclusion of Medicare supplemental plans prior to November 5, 1990.* This section is not applicable to Medicare supplemental plans:

(1) That have been in continuous effect without amendment since prior to November 5, 1990; and

(2) For which the facility of the Uniformed Services (or other authorized representative of the United States) makes a determination, based on documentation provided by the Medicare supplemental plan, that the plan agreement clearly excludes payment for services covered by this section. Plans entered into, amended or renewed on or after November 5, 1990, are subject to this section, as are prior plans that do not clearly exclude payment for services covered by this section.

[57 FR 41102, Sept. 9, 1992, as amended at 59 FR 49003, Sept. 26, 1994]

§ 220.11 Special rules for automobile liability insurance and no-fault automobile insurance.

(a) *Active duty members covered.* In addition to Uniformed Services beneficiaries covered by other provisions of this part, this section also applies to active duty members of the Uniformed Services. As used in this section,

“beneficiaries” includes active duty members.

(b) *Effect of concurrent applicability of the Federal Medical Care Recovery Act—*

(1) *In general.* In many cases covered by this section, the United States has a right to collect under both 10 U.S.C. 1095 and the Federal Medical Care Recovery Act (FMCRA), Pub. L. 87-693 (42 U.S.C. 2651 et seq.). In such cases, the authority is concurrent and the United States may pursue collection under both statutory authorities.

(2) *Cases involving tort liability.* In cases in which the right of the United States to collect from the automobile liability insurance carrier is premised on establishing some tort liability on some third person, matters regarding the determination of such tort liability shall be governed by the same substantive standards as would be applied under the FMCRA including reliance on state law for determinations regarding tort liability. In addition, the provisions of 28 CFR part 43 (Department of Justice regulations pertaining to the FMCRA) shall apply to claims made under the concurrent authority of the FMCRA and 10 U.S.C. 1095. All other matters and procedures concerning the right of the United States to collect shall, if a claim is made under the concurrent authority of the FMCRA and this section, be governed by 10 U.S.C. 1095 and this part.

(c) *Exclusion of automobile liability insurance and no-fault automobile insurance plans prior to November 5, 1990.* This section is not applicable to automobile liability insurance and no-fault automobile insurance plans:

(1) That have been in continuous effect without amendment since prior to November 5, 1990; and

(2) For which the facility of the Uniformed Services (or other authorized representative of the United States) makes a determination, based on documentation provided by the third party payer, that the policy or plan clearly excludes payment for services covered by this section. Plans entered into, amended or renewed on or after November 5, 1990, are subject to this section, as are prior plans that do not clearly exclude payment for services covered by this section.

[57 FR 41103, Sept. 9, 1992]

§ 220.12 Definitions.

(a) *Automobile liability insurance.* Automobile liability insurance means insurance against legal liability for health and medical expenses resulting from personal injuries arising from operation of a motor vehicle. Automobile liability insurance includes:

(1) Circumstances in which liability benefits are paid to an injured party only when the insured party's tortious acts are the cause of the injuries; and

(2) Uninsured and underinsured coverage, in which there is a third party tortfeasor who caused the injuries (i.e., benefits are not paid on a no-fault basis), but the insured party is not the tortfeasor.

(b) *CHAMPUS supplemental plan.* A CHAMPUS supplemental plan is an insurance, medical service or health plan exclusively for the purpose of supplementing an eligible person's benefit under CHAMPUS. (For information concerning CHAMPUS, see 32 CFR part 199.) The term has the same meaning as set forth in the CHAMPUS regulation (32 CFR 199.2).

(c) *Facility of the Uniformed Services.* A facility of the Uniformed Services means any medical or dental treatment facility of the Uniformed Services (as that term is defined in 10 U.S.C. 101(43)). Contract facilities such as Navy NAVCARE clinics and Army and Air Force PRIMUS clinics that are funded by a facility of the Uniformed Services are considered to operate as an extension of the local military treatment facility and are included within the scope of this program. Facilities of the Uniformed Services also include several former Public Health Services facilities that are deemed to be facilities of the Uniformed Services pursuant to section 911 of Pub. L. 97-99 (often referred to as "Uniformed Services Treatment Facilities" or "USTFs").

(d) *Healthcare services.* Healthcare services include inpatient, outpatient, and designated high-cost ancillary services.

(e) *Inpatient hospital care.* Treatment provided to an individual other than a transient patient, who is admitted (i.e., placed under treatment or observation) to a bed in a facility of the uniformed

services that has authorized beds for inpatient medical or dental care.

(f) *Insurance, medical service or health plan.* Any plan or program (subject to the limitations of §220.6) that provides compensation or coverage for expenses incurred by a beneficiary for health or medical services and supplies. It includes:

(1) Plans or programs offered by insurers, corporations, organized health care groups or other entities.

(2) Plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled as a result of employment or membership in, or association with, an organization or group; and

(3) Medicare supplemental insurance plans.

(g) *Medicare eligible provider.* Medicare participating (institutional) providers and physicians, suppliers and other individual providers eligible to participate in the Medicare program.

(h) *Medicare supplemental insurance plan.* A Medicare supplemental insurance plan is an insurance, medical service or health plan primarily for the purpose of supplementing an eligible person's benefit under Medicare. The term has the same meaning as "Medicare supplemental policy" in section 1882(g)(1) of the Social Security Act. In addition, consistent with 42 CFR 403.206(c), a Medicare supplemental insurance plan may consist of two policies issued in conjunction with one another, one by a nonprofit hospital association and the other by a medical association, in cases in which state law prohibits the inclusion of all benefits in a single policy.

(i) *No-fault insurance.* No-fault insurance means an insurance contract providing compensation for health and medical expenses relating to personal injury arising from the operation of a motor vehicle in which the compensation is not premised on who may have been responsible for causing such injury. No-fault insurance includes personal injury protection and medical payments benefits in cases involving personal injuries resulting from operation of a motor vehicle.

(j) *Third party payer.* A third party payer is an entity that provides an insurance, medical service or health plan by contract or agreement. It includes:

(1) State and local governments that provide such plans.

(2) Insurance underwriters and private employers (or employer groups) offering self-insured or partially self-insured and/or partially underwritten health insurance plans; and

(3) Automobile liability insurance and no-fault insurance carriers.

(k) *Third party payer plan.* A third party payer plan is any plan provided by a third party payer, but not an income supplemental plan or workers compensation plan.

(l) *Uniformed Services beneficiary.* For purposes of this part, a Uniformed Services beneficiary is any person who is covered by 10 U.S.C. 1074(b), 1076(a), or 1076(b). For purposes of § 220.11 (but not for other sections), a Uniformed Services beneficiary also includes active duty members of the Uniformed Services.

[57 FR 41103, Sept. 9, 1992]

PART 221—DEPARTMENT OF DEFENSE PARTICIPATION IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)

Sec.

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AUTHORITY: Public Law 99-660, title IV (44 U.S.C. 11131-11152).

SOURCE: 55 FR 50321, Dec. 6, 1990, unless otherwise noted.

§ 221.1 Purpose.

This part:

(a) Establishes DoD policy, assigns responsibilities, and prescribes procedure for implementing Public Law 99-660, title IV and the objectives of the Memorandum of Understanding (MOU) between the Department of Health and Human Services (DHHS) and the Department of Defense, September 21, 1987, which outlines the DoD's partici-

pation in the National Practitioner Data Bank (NPDB).

(b) Specifies the content of confidential reports to the NPDB established under part B of Public Law 99-660, and reporting responsibilities.

§ 221.2 Applicability and scope.

This part applies to:

(a) The Office of the Secretary of Defense (OSD) and the Military Departments (including their National Guard and Reserve components). The term, "Military Departments," as used herein, refers to the Army, the Navy, and the Air Force.

(b) Healthcare personnel who are in professions required to possess a license under DoD Directive 6025.6¹ and/or who are granted individual clinical privileges.

§ 221.3 Definitions.

(a) *Healthcare entity.* A hospital, ambulatory health clinic, or dental clinic with an independent healthcare practitioner staff that carries out professional staff review and provides healthcare to medical or dental patients; and applicable professional staff components of each Service, as designated by the respective Surgeon General, which also perform peer review as part of the quality assurance program.

(b) *Licensed healthcare practitioner.* Any healthcare practitioner of one of the professions required to possess a professional license, as prescribed in DoD Directive 6025.6.

(c) *The National Practitioner Data Bank (NPDB).* The organization developed according to Public Law 99-660 to receive and provide data on professional competence and conduct of physicians, dentists, and other licensed healthcare providers. In Public Law 99-660, it is referred to as the "National Data Bank." That name was changed after the MOU was signed.

§ 221.4 Policy.

It is DoD policy that:

(a) Professional review shall occur in every case of alleged malpractice.

¹Copies may be obtained, at cost, from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161.